STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005036	A. BUILDING: _____ B. WING _____	12/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH MORGAN HOSPITAL I	2209 JOHN R WOODEN DR MARTINSVILLE, IN 46151

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State complaint. Complaint Number: IN00113870 Substantiated: No deficiencies related to the allegations are cited. Date: 12-11-12 Facility: 005036 Surveyor: Billie Jo Fritch RN, MSN, MBA Public Health Nurse Surveyor Indiana University Health Morgan Hospital, Inc. was found in compliance with 410 IAC 15-1.6-5, Psychiatric Services, Hospital Licensure Rules. QA: claughlin 03/08/13	S 000		